

STATE OF RHODE ISLAND UNIFORM ACCIDENT REPORT

Reporting Agency: _____		Dept. Code: _____	Type of Collision: _____ i.e. (car/car)	Report No: _____
Date of Accident: ____/____/____	()Sun ()Mon ()Tues	()Public Property	()Investigated at Scene	Posted Speed: _____
Time: ()am ()pm	()Wed ()Thu ()Fri ()Sat	()Private Property	()Walk-In ()Other	mph/km

Location:

Street/Highway: _____	City/Town: _____	Intersection with: _____
Exact Location if not at Intersection: _____	()North ()South ()East ()West	Nearest Intersection Street: _____
Feet/or _____ Miles: _____		Mile Marker: ____/____/____/____

Operator #1

Name of Operator: _____	Date of Birth: _____	M() F()	Social Security Number (Optional): _____
Street/Mailing Address: _____	City/Town: _____	State: _____	Zip Code: _____
License No: _____ State: _____	()Operator ()Chauffeur ()Permit		Telephone (Optional): _____
Restriction: _____	Transporting Placardable HM Y() N()	()Motorcycle	
Charges (If Applicable) Citation # _____	Statute # (1) _____ (2) _____ (3) _____	()CDL/Req. Yes No	Vehicle Direction: N() S() E() W()

Vehicle Type: #1

()Passenger Car ()Pick-up Van ()Schl. Bus ()Other Bus ()Motor Cycle ()T.Trailer ()Straight Trk. ()Tractor only
()Other Type Vehicle

Vehicle #1

Registration No. _____	Plate Type: _____	Year: _____ Make: _____	V.I.N. Number: _____
State: _____		Color/Model: _____	
Registered Owner's Name: _____	Street/Mailing Address: _____	City/Town: _____	Zip: _____
		State: _____	
Name of Insurance Company: _____	Insurance Policy Number: _____	Owner's Telephone (Optional): _____	

Air Bags Available: ()Yes ()Unknown Air Bags Activated: ()Yes ()No ()One ()Two ()Driven ()Towed

Operator #2

Name of Operator: _____	Date of Birth: _____	M() F()	Social Security Number (Optional): _____
Street/Mailing Address: _____	City/Town: _____	State: _____	Zip Code: _____
License No: _____ State: _____	()Operator ()Chauffeur ()Permit		Telephone (Optional): _____
Restrictions: _____	Transporting Placardable HM Y() N()	()Motorcycle	
Charges (If Applicable) Citation # _____	Statute # (1) _____ (2) _____ (3) _____	()CDL/Req. Yes No	Vehicle Direction: N() S() E() W()

Vehicle Type: #2

()Passenger Car ()Pick-up Van ()Schl. Bus ()Other Bus ()Motor Cycle ()T.Trailer ()Straight Trk. ()Tractor only
()Other Type Vehicle

Vehicle #2

Registration No. _____	Plate Type: _____	Year: _____ Make: _____	V.I.N. Number: _____
State: _____		Color/Model: _____	
Registered Owner's Name: _____	Street/Mailing Address: _____	City/Town: _____	Zip: _____
		State: _____	
Name of Insurance Company: _____	Insurance Policy Number: _____	Owner's Telephone (Optional): _____	

Air Bags Available: ()Yes ()Unknown Air Bags Activated: ()Yes ()No ()One ()Two ()Driven ()Towed
Garage:

DMV/94

Injury Code:

A) Bleeding/Broken Bones	B) Bruises/Abrasions	C) No Visible Injury/Complaints of Pain	D) Fatal
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Seat Numbers:

3	6	9
2	5	8
1	4	7

Occupant/Injury Information: (Please Use Appropriate Code & Seat Number): Y/N

Name of Occupant: _____						() M () F	Date of Birth: ____/____/____	
Street/Mailing Address: _____						State _____ Zip _____		
City/Town: _____								
Vehicle #	Seat Loc.	Seat Belt	Eject	Injury Code	Pedes/Bicy.Helmet	Transported	Refuse Treat.	Own Doctor

Name of Occupant: _____						() M () F	Date of Birth: ____/____/____	
Street/Mailing Address: _____						State _____ Zip _____		
City/Town: _____								
Vehicle #	Seat Loc.	Seat Belt	Eject	Injury Code	Pedes/Bicy.Helmet	Transported	Refuse Treat.	Own Doctor

Name of Occupant: _____						() M () F	Date of Birth: ____/____/____	
Street/Mailing Address: _____						State _____ Zip _____		
City/Town: _____								
Vehicle #	Seat Loc.	Seat Belt	Eject	Injury Code	Pedes/Bicy.Helmet	Transported	Refuse Treat.	Own Doctor

Witness Information:

Name of Witness: _____			Statement Attached: () Yes () No		Telephone (Optional): _____	
Street/Mailing _____						
City/Town: _____ State: _____ Zip _____						

Non-Vehicle Property Damage:

Name of Owner: _____		Briefly Describe Non-Vehicle Property Damage: Damage by Vehicle # _____	
Street/Mailing _____		_____	
City/Town: _____ State: _____ Zip _____		_____	

Road Conditions:

Type Road	Traffic Cont.	Road Surface	Road Cond.	Weather	Light Cond.	Traffic Cond.	Type Location
Expressway	Stop Sign	Concrete	Dry	Clear	Daylight	Light	Residential
Divided h/w	Traffic Sig.	Asphalt	Wet	Rain	Dawn/Dusk	Med.	Rural
Exit Ramp	Officer	Gravel/Dirt	Snow/Ice	Snow	Darkness	Heavy	Comm/Indust.
2 Lanes	R/R Signal	Sand Cover	Construction	Sleet	Lighted		
3 Lanes	No Controls		Repair	Fog/Mist	Not Lighted		
4-Lanes	Other						
One-Way							
Un-Paved							

Collision/Alcohol Information:

Vehicle #		Operator #		Operator#		Physical Condition of Operator:	Alcohol Data	
Manner Of Collision	Collision With	1	2	1	2		1	2
Angle	Barrier			Drivers/What they are doing prior to accident			Had Been Drinking	Test Given
Merging	Guard Rail			Changing Lns			Obviously Impaired	Refused
Sideswipe same Dir.	Curb			Making (R) Turn			Physical Handicap	Breath
Sideswipe Opp Dir.	Bridge Abut.			Making (L) Turn			View Obstructed	Blood
Head-On	Bridge Rail			Making (U)			Sleepy/Tired	Urine
Rear-End	Sign Post			Slowing/Stpg			Fell Asleep	Not App.
Broadside	Pole			Start in Traf.			Impairment U/K	
Rollover	Tree			Backing				
Ran off/road	Other:			Parked				

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Vehicle #1

Vehicle #1

Briefly Describe Damage to Vehicle Caused by Accident/Including Glass Breakage: _____

Briefly Describe Specific Vehicle Damage which Pre-existed the Accident/Including Glass Breakage, If Known: _____

Briefly Describe Damage to Contents of Vehicle - Caused by Accident, If Any: _____

Vehicle #2

Vehicle #2

Briefly Describe Damage to Vehicle Caused by Accident/Including Glass Breakage: _____

Briefly Describe Specific Vehicle Damage which Pre-existed the Accident/Including Glass Breakage, If Known: _____

Briefly Describe Damage to Contents of Vehicle - Caused by Accident, If Any: _____

Trailor Information:

Reg. No:	State:	Make:	Vin. #:	Towed by: () 1 () 2
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Summary Information:

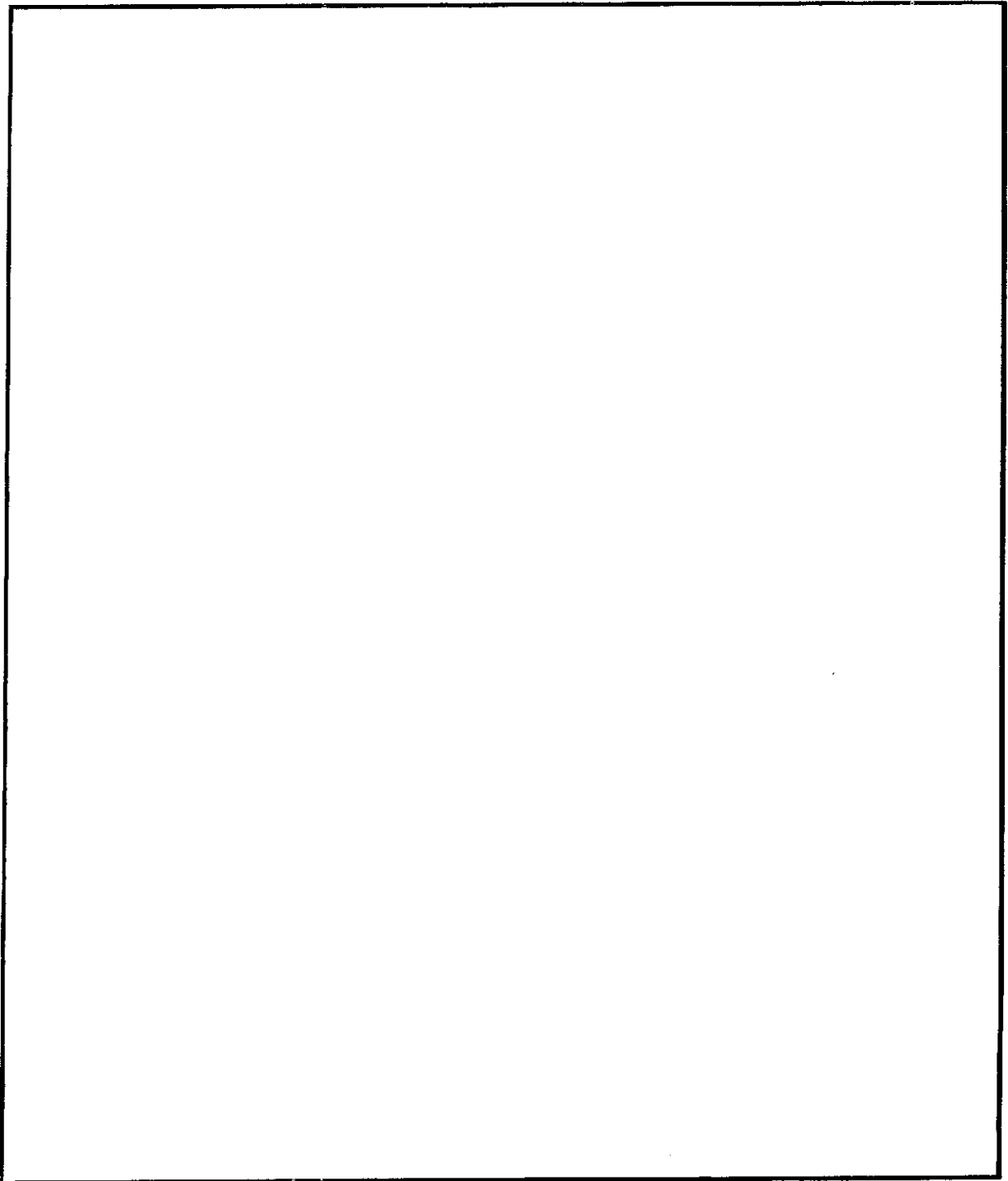
Briefly Describe What Happened and Indicate Specific Description of all Accident Debris, Refer to Vehicle by Number: _____

Photos Taken	() (Y) (N)	Diagram Attached	() (Y) (N)	Operator Statement	() (Y) (N)	Supplement Reports	() (Y) (N)	Supplemental Truck/ Bus Report	() (Y) (N)
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Investigating Officer: _____ <i>Printed Name</i> _____ <i>& Signature</i>	Badge No: _____	Date of Report: _____
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A Copy of this Report Must Be Forwarded to:
The Department of Administration Safety Responsibility Section
345 Harris Avenue
Providence, Rhode Island 02909-0345
(Within 15 Days - Per: Rhode Island General Law #31-26-9)

DIAGRAM OF ACCIDENT:



SUPPLEMENTAL TRUCK/BUS ACCIDENT REPORT

Do not Complete this Form Unless:

One or More Qualified Vehicles was involved, and, One or More Qualifying Injuries was sustained, or...	One or More Vehicles was towed from the scene, or... One or More Vehicles was Provided Assistance.
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Total Number of Qualifying Vehicles Involved:

Trucks with (6) or More Tires or Hazardous Material Placards: ()	Buses Designed to Carry (16) or More Persons: ()
Total Number of Supplemental Forms: ()	Interstate Carrier: () Yes () No

Accident Report Number: _____	Date Accident Occurred: / /	Time Accident Occurred (Military): : :
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Carrier Information: "Identification Numbers"

None = "0" → ()	US DOT: _____ (7-Numbers)	State No: _____	State: _____	ICC/MC: _____ (6-numbers)
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Accident Location Information:

Location: (Number/Name of Highway/Street): _____	City/Township: _____	County: _____
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(Enter # _____)

Source of Information:

Carrier Name:			
(1) Side of Vehicle	(2) Shipping Papers (Truck) or Trip Manifest (Bus)		
(3) Driver	(4) Log Book		
Address: (Street/Box#) _____	City: _____	State: _____	Zip Code: _____

Driver Information:

Name: _____ Last First M.I.	DOB: _____ Mo. Day Year	License # _____	State: _____
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(Enter # _____)

Vehicle Configuration:

(0) Any Four (4) Tire Vehicle	(4) Truck/Trailer	(7) Tractor/Double
(1) Bus/Seats for >15 People, including Driver	(5) Truck Tractor/Boattail	(8) Tractor/Triple
(2) Single-Unit Truck (2-Axle, 6-Tire)	(6) Tractor/Semitrailer	(9) Unknown Truck, Cannot Classify
(3) Single-Unit Truck (3 or more Axles)		

(Enter # _____)

Cargo Body Type:

(1) Bus designed to carry 16 or more persons	(4) Flatbed	(7) Auto Transporter
(2) Van/Enclosed Box	(5) Dump	(8) Garbage/Refuse
(3) Cargo Tank	(6) Concrete Mixer	(9) Other

Gross Vehicle Weight Rating:

Truck/Tractor or Bus: _____ Lbs.	Trailer(s) Total: _____ Lbs.	Total Amount: _____ Lbs.	Total No. of Axles: _____ (Inc. Trailer)
Vehicle Identification No. (VIN): _____	Vehicle License No: _____	License/State: _____	

Hazardous Materials Involvement:

Did Vehicle Have a Hazardous Material Placard? () Yes () No	If "Yes" from Placard Indicate Name or 4 digit Number: _____ (from diamond or box)
One (1) Digit Number From Bottom of Diamond ()	Was Hazardous Material Released from this Vehicle's Cargo () Yes () No

FATALITY DATA FORM
POLICE

NAME OF FATALITY: _____

LOCATION: _____

CITY: _____

DATE: ____ / ____ / ____

POSTED SPEED LIMIT: _____ MPH

ACTUAL OR CALCULATED SPEED OF VEHICLE: _____ MPH

ALIGNMENT OF ROAD: STRAIGHT _____ CURVE _____ UNKNOWN _____

GRADE OF ROAD: LEVEL _____ GRADE _____ UNKNOWN _____

ROADWAY FLOW: NOT PHYSICALLY DIVIDED: _____
DIVIDED HIGHWAY: _____
MEDIAN STRIP _____
GUARDRAIL _____
OTHER TRAFFIC BARRIER _____
ONE WAY TRAFFICWAY: _____
UNKNOWN: _____

NUMBER OF LANES ON ROADWAY: _____

TRAFFIC CONTROLS: NO CONTROLS _____
FLASHING TRAFFIC SIGNAL _____
ON COLOR TRAFFIC SIGNAL _____
STOP SIGN _____
YIELD SIGN _____
SCHOOL ZONE SIGN _____
PEDESTRIAN SIGNAL _____
OTHER _____
UNKNOWN _____

WERE TRAFFIC CONTROLS FUNCTIONING ? YES _____ NO _____

WAS SPEEDING INVOLVED ?	DRIVER #1	DRIVER #2	DRIVER #3
YES			
NO			
SUSPECTED			

WAS ALCOHOL INVOLVED ? (THIS IS STRICTLY CONFIDENTIAL)			
YES			
NO			
SUSPECTED			

ANY DEFECTS IN CARS RELATED TO ACCIDENT ? IF YES, WHAT KIND?
VEHICLE # 1 _____ VEHICLE #2 _____ VEHICLE #3 _____

PLEASE SPECIFY THE NAME OF EMS UNIT THAT RESPONDED _____

WAS THIS PERSON WEARING ANY KIND OF RESTRAINT DEVICE?
YES _____ NO _____ IF YES, WHAT KIND? _____